DURABLE MEDICAL EQUIPMENT PAYMENT SYSTEM

*payment***basics**

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Medical equipment needed at home to treat a beneficiary's illness or injury is covered under the durable medical equipment (DME) benefit. Medicare spent about $8.2 billion on DME in fiscal year 2011. Oxygen and related supplies has been the largest category of DME, representing about a quarter of DME spending in recent years.

Wheelchairs and respirators are typical of the equipment Medicare pays for under this benefit. To be covered, the equipment must:

- withstand repeated use,
- primarily serve a medical purpose, and
- generally not be useful to a person without an illness or injury.

Thus, expendable supplies, such as bandages or incontinence pads, or otherwise useful equipment such as a humidifier, would not be covered under this benefit.

Medicare also covers prosthetics, orthotics, and some medications under its DME benefit. Covered prosthetics generally are artificial limbs; orthotics include orthopedic braces and some supportive garments. Medication that is necessary to the function performed by durable equipment is also covered under this benefit—for example, heparin administered in a home dialysis system or albuterol in a nebulizer.

Beneficiaries are responsible for 20 percent coinsurance.

Supplier enrollment safeguards have been progressively strengthened. Accreditation and surety bonds were required in 2009, and licensure and physical space requirements—among others—were added effective September 27, 2010.

The equipment Medicare buys

Medicare uses fee schedules to set prices for noncustomized equipment, prosthetics, and orthotics. These items are assigned to categories and to product groups within those categories. The categories are based on the nature of the item: whether or not it is inexpensive, needs frequent service, or is a rental item subject to an explicitly limited period of use. The categories are:

- inexpensive or routinely purchased equipment,
- items requiring frequent and substantial servicing,
- prosthetic and orthotic devices,
- capped rental items, and
- oxygen and oxygen equipment.

Within the categories, items are further categorized into about 2,000 product groups. Examples of product groups are high-strength lightweight wheelchairs and rental portable oxygen systems. All items within the same product group have the same payment rate.

Setting the payment rates

Generally, the current fees are an average of the allowed charges from 1986 and 1987, adjusted by the consumer price index for all urban consumers to account for inflation. Several exceptions to this general rule are:

- Customized equipment and medications are paid at rates that are determined item by item, by the regional carrier.
- Prices for most medications used in conjunction with DME are set at 106 percent of the average sales price (ASP). Infusion drugs administered with an external pump are paid at 95 percent of the October 1, 2003, average wholesale price (AWP).
- Prices for home oxygen are based on the median 2002 Federal Employee Health Benefit plan price.

To capture geographic differences in prices for equipment, Medicare uses a separate fee schedule for each state. The program pays the lesser of the provider's charge and the state fee schedule amount (Figure 1). State fee schedule rates are subject to a national floor and ceiling to limit the variability in prices across the country. The fees for prosthetics and

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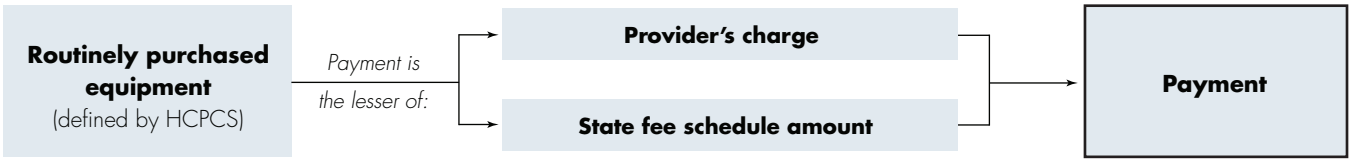
Figure 1 Durable medical equipment payment system



Note: HCPCS (Healthcare Common Procedure Coding System).

orthotics are also determined state by state but are subject to regional limits. There are no state or regional variations in the price of drugs that Medicare purchases through this benefit. The applicable fee schedule is determined by the location of beneficiaries' residences rather than the location of the DME provider.

Competitive bidding

Qualified suppliers were allowed to bid against one another to test a new method of pricing and purchasing DME in two areas between 2000 and 2002. As an incentive to compete, suppliers whose bids were not among the lowest priced were excluded from the market or not allowed to serve new clients. In that demonstration, competitive bidding lowered prices for selected DME items between 17 and 22 percent. Analyses of the demonstration did not find serious quality or access issues.

As mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), a competitive bidding process for DME was to be phased in nationwide, starting with 10 metropolitan statistical areas (MSAs) in 2008 and expanding to 80 MSAs by 2009. Contracts to supply DME were to be awarded to the winning bidders.

The first 10 MSAs were:

- Charlotte–Gastonia–Concord, NC–SC
- Cincinnati–Middletown, OH–KY–IN
- Cleveland–Elyria–Mentor, OH
- Dallas–Fort Worth–Arlington, TX
- Kansas City, MO–KS
- Miami–Fort Lauderdale–Miami Beach, FL
- Orlando–Kissimmee, FL
- Pittsburgh, PA
- Riverside–San Bernardino–Ontario, CA
- San Juan–Caguas–Guaynabo, PR

The first round of competition took place and contracts were awarded and took effect July 1, 2008. CMS estimated that the program and beneficiaries would save an average of 26 percent on the competitively bid items.

Partly because of some difficulties during implementation, particularly with the automated system for submitting bids, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) terminated the contracts awarded in round one, delayed the competitive bidding process, and made several other changes to the program. To offset the cost of delaying the program, the fee schedule amount for any item selected for competitive acquisition before July 1, 2008, was not increased by the scheduled amount and was instead reduced by 9.5 percent nationwide in 2009. The new first round of competition began in October 2009 and excluded the San Juan MSA and negative pressure wound therapy items. The new contracts and single payment rates for each MSA went into effect January 2011. In the first year of implementation CMS estimates savings of about $200 million, or 42 percent less than would have been paid under the fee schedule. Of this reduction in spending, 35 percent is due to lower prices paid by Medicare, and 7 percent due to lower volume. CMS reports there have been no major issues with beneficiary access in those areas. The second round of competition started in 2011 in 91 additional MSAs. CMS expects payments and contracts under the second round will start in 2013 as will the competitive national contracts for mail order diabetic supplies. ■